NOTICE OF INTENT TO RECOVER PAST-DUE HEALTH BENEFITS PREMIUMS (NO RETURN TO DUTY) For use of this form, see AR 37-105; the proponent agency is USAFAC.	DATE
TO: SSN:	FROM: PCN:

Federal Employees Health Benefits program regulations (Part 890 of Title 5, Code of Federal Regulations) state that program enrollees are responsible for payment of the employee share of the cost of their enrollment for every pay period in which the enrollment continues. The regulations further provide that an employee is deemed to consent to withholdings from salary to cover past-due premiums for coverage which continued during pay periods for which there was no withholding of premiums.

Our records show that you are indebted as described below. You may pay the full amount by check or money order made payable to _____ . However, if you believe that the amount due is incorrect, or if you have any questions about the indebtedness, please contact the person named below within 15 days. If we do not hear from you, we shall take action to recover the amount due from the Civil Service Retirement System or any other monies owed to you by the Federal Government.

PAY PERIODS NOT COVERED BY WITHHOLDINGS		NAME OF CONTACT PERSON
TOTAL PREMIUM DUE FOR THESE PAY PERIODS		ADDRESS
AMOUNTS YOU HAVE ALREADY PAID		
TOTAL AMOUNT DUE		TELEPHONE NUMBER
ENROLLMENT CODE	BIWEEKLY RATE $	
TYPED NAME, GRADE AND TITLE OF CERTIFYING OFFICIAL		SIGNATURE

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